

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-011637

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 1534

FILED MAR 21 1963

1. PLACE OF DEATH a. COUNTY <b>JACKSON</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>JACKSON</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>KANSAS CITY</b>		c. CITY OR TOWN <b>KANSAS CITY</b>	
Length of stay in lb. <b>50 yrs.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) <b>TRINITY LUTHERAN HOSPITAL</b>		d. STREET ADDRESS (If outside, give location) <b>3104 JEFFERSON STREET</b>	
HOSPITAL OR INSTITUTION Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) <b>AUGUSTA ANDERSON GOLD</b>			4. DATE OF DEATH Month <b>MARCH</b> Day <b>8</b> Year <b>1963</b>		
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>3/14/1880</b>	9. AGE (last birthday) <b>82</b>	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Interess</b>			11. BIRTHPLACE (City and state or country) <b>SWEDEN</b>		
10b. KIND OF BUSINESS OR INDUSTRY <b>for self</b>			12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		
13a. FATHER'S NAME <b>John Anderson</b>		13b. MOTHER'S MAIDEN NAME <b>Annalatta Peterson</b>		14. NAME OF HUSBAND OR WIFE <b>John Gold</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>[REDACTED]</b>		
17. INFORMANT <b>MRS. DOROTHY OSBORNE</b>			Address <b>3104 JEFFERSON ST. KANSAS CITY MO.</b>		

18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypostatic Pneumonia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>36 hrs</b>
DUE TO (b) <b>C. V. A.</b>		<b>5 days</b>
DUE TO (c) <b>Essential Hypertension.</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		
<div> <div> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> </div> <div> 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> </div> <div> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) </div> </div>		
<div> <div> 20c. TIME OF INJURY Hour - Month, Day, Year a.m. p.m. </div> <div> 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> </div> <div> 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) </div> <div> 20f. CITY, TOWN, OR LOCATION <b>3-8-63</b> </div> </div>		
<div> <div> 21. I attended the deceased from <b>Jun 1963</b> to <b>8 Mar '63</b> and last saw her alive on <b>8 Mar '63</b> </div> <div> 22a. SIGNATURE (Degree or title) <b>Robert M. Myers M.D.</b> </div> <div> 22b. ADDRESS <b>906 Grand Ave.</b> </div> <div> 22c. DATE SIGNED <b>8 Mar 63</b> </div> </div>		

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>3-11-63</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Forest Hill</b>	23d. LOCATION (City, town, or county) (State) <b>Kansas City Mo.</b>
24. FUNERAL DIRECTOR <b>D.W. NEW COMERS SONS</b>		25. DATE RECD. BY LOCAL REG. <b>3-8-63</b>		26. REGISTRAR'S SIGNATURE <b>Arthur Long</b>
ADDRESS <b>1331 BRUSH CARR</b>				

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK

OR

TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

Robert M. Myers MEDICAL CERTIFICATION

VS 300  
Rev. 4/59

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Dr. Robert M. Myers  
1304 Reatto Road  
2130-4100

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed

*Jess T. Deen*

Licensed Embalmer No. 445-3

P. O. Address

*Thomson City*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.